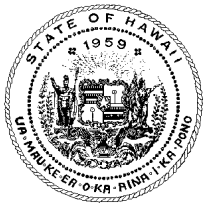

STATE OF HAWAII
CRIME VICTIM COMPENSATION COMMISSION
1136 Union Mall, Room 600
Honolulu, Hawaii 96813
Telephone: 808 587-1143
FAX 808 587-1146

I, _____ (____/____/____) authorize the release of protected health information from:
(name of patient) (Date of Birth)

Hospital/Doctor Name: _____

Hospital/Doctor Address: _____

_____

This information is required to process a claim with the Crime Victim Compensation Commission.

The Crime Victim Compensation Commission (Commission), requests all protected medical records and reports (x-rays not required) and an itemized statement of expenses, including any insurance payments, provider adjustments and/or patient payments

for the period: ___/____/____ to present.
(Date of Crime)

Specifically, the Commission also requests:

- Substance abuse treatment records
- Mental Health treatment records
- Sexually transmitted diseases including AIDS and HIV

The Commission releases the above named provider, its employees, agents, and staff physicians from all liability and all claims of any nature pertaining to the disclosure of information described above. This information is solely for use in the Commission's determination of eligibility for payment of your services and will not be re-disclosed to third parties.

The requested records are required to substantiate treatment and charges. The Commission will not pay for documents/copying fees. Federal Public Law 103-322 (H.R. 3355) Section 230202, provides that the Commission should be considered last payor and not a third party liability. Therefore, all insurance claims should be filed accordingly. If the insurance carrier denied the claim, please submit the denial document.

Authorization by the signatory is voluntary and may be revoked at any time upon receipt of written notice. Additionally, the service provider will not use this form to set as conditions for treatment, payment, enrollment, or eligibility for benefits except as allowed under federal privacy laws for: 1) research-related treatment, 2) health care provided solely for disclosure to a third party, or 3) health plan initial enrollment/eligibility determinations, underwriting, or risk rating determinations.

Patient Name: _____ Relation to Patient: _____
(or legal guardian if Patient is a minor or incapacitated)

Signature of Patient/Legal Guardian: _____ Date: _____

Legal authorization to serve as "designated patient representative": _____

Copy of documentation obtained for permanent record: □ Yes □ No